

Exhibit 1



Charter Communications, Inc.
Short-Term Disability Program

(a Component Program of the
Charter Communications, Inc.
Welfare Benefit Plan)

Summary Plan Description

Effective January 1, 2017

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INTRODUCTION

This Summary Plan Description (“SPD”) describes the provisions of the Charter Communications, Inc. Short-Term Disability Program (the “Short-Term Disability Program”), which is a component program of the Charter Communications, Inc. Welfare Benefit Plan (the “Plan”) effective January 1, 2017. We have tried to explain Short-Term Disability Program provisions in everyday language, but you will come across phrases that have specific meanings within the context of the Short-Term Disability Program. The meanings of these capitalized terms are available in the Definitions subsection. Please be sure to read Other Information You Should Know for important administrative guidelines and facts about your rights under applicable law and the Short-Term Disability Program.

We have tried to ensure that this SPD accurately reflects the provisions of the Plan and the Short-Term Disability Program. The Plan documents govern the Plan and include additional details on how the Plan operates. If there is any discrepancy between this SPD and the Plan document, the Plan document governs. You may obtain a free copy of the Plan document by writing to the Plan Administrator.

This SPD describes the benefits under the Short-Term Disability Program in effect beginning January 1, 2017. This SPD should not be construed as a promise that benefits will not be changed or terminated during your employment, or after your employment while still covered by the Short-Term Disability Program (including, but not limited to, changes in the amount you are required to pay for coverage). Charter Communications, Inc. (the “Company”) or any successor reserves the right to amend, modify, suspend or terminate the Plan or the Short-Term Disability Program, including any underlying contract or policy, in whole or in part, at any time and for any reason, by action of the Company.

Therefore, the benefits described in this SPD are not vested benefits and, in no event, will you become entitled to vested rights under the Short-Term Disability Program. Please also note that neither the Plan nor the Short-Term Disability Program create an employment contract between you and any Participating Company, or give you any right, expressed or implied, of continued employment with any Participating Company.

Charter Communications, Inc. is hereafter referred to as “Charter” or “the Company.”

SHORT-TERM DISABILITY PROGRAM BENEFIT HIGHLIGHTS

The Short-Term Disability Program is administered by Sedgwick Claims Management Services, Inc. ("Sedgwick"). Sedgwick can be reached at the following address and telephone numbers:

Sedgwick
PO Box 14667
Lexington, KY 40512-466
Phone: 877-892-6707
Fax: 859-280-2880

Short-Term Disability Program Benefit Highlights	
Weeks Disabled	Benefit ¹
You must complete the Elimination Period, which is seven (7) calendar days, and exhaust your Participating Company's accrued sick, personal and vacation time (subject to applicable state law) before benefits will begin.	2–12 weeks 75% of weekly Covered Compensation
	13–26 weeks 66 2/3% of weekly Covered Compensation

¹This amount may be reduced by other sources of income or statutory benefits, if applicable.

Important Note on Eligibility

Employees working in Hawaii and employees working in California and New York who are subject to a collective bargaining agreement are not eligible for benefits under the Short-Term Disability Program described in this SPD. Short-term disability benefits for these employees are set by the applicable state or local law. If you work in Hawaii, you should contact your local Human Resources Department for information on eligibility for short-term disability benefits.

ABOUT YOUR PARTICIPATION

This section includes important information about your eligibility and participation in the Short-Term Disability Program.

Who is Eligible

You are eligible to participate in the Short-Term Disability Program if you are a full-time Employee of a Participating Company who is regularly scheduled to work at least 30 hours per week, your primary place of employment is not in Hawaii, and you are not subject to a collective bargaining agreement.

When Coverage Begins

Effective January 1, 2017, if you are an eligible Employee of a Participating Company, your coverage under the Short-Term Disability Program begins on the first day after you have completed one year of employment.

If you are not Actively at Work on the date your coverage is supposed to begin, the effective date of your coverage will be delayed. Prior to July 28, 2017, your coverage will start on the first day of the month following the date you are next Actively at Work. Effective July 28, 2017, your coverage will start immediately upon your return to work.

If you are a rehired Employee, your rehire date determines when your Short-Term Disability Coverage begins.

- If you are rehired less than 12 months after your termination and you had previously satisfied the waiting period, your disability coverage begins on your rehire date.
- If you are rehired less than 12 months after your termination and you had not previously satisfied the waiting period, your prior service will be applied toward the waiting period.
- Otherwise, your disability coverage begins on the first day following one year of employment.

Special coverage provisions may apply in the case of corporate transactions such as a merger or acquisition. For example if you are an eligible Employee – that is, you are regularly scheduled to work at least 30 hours per week – and you were covered by and had satisfied the waiting period for coverage to begin under the separate short-term disability program maintained under the Time Warner Cable Benefits Plan (i.e., four months of active employment) or the Bright House Networks Disability Plan (i.e., one month of active employment) prior to the merger of those plans into the Charter Communications, Inc. Welfare Benefit Plan on December 31, 2016, then your coverage under the Short-Term Disability Program began on January 1, 2017.

When Your Eligibility for Short-Term Disability Coverage Ends

Your Short-Term Disability coverage ends on the earliest of:

- The date your employment terminates
- The date you are no longer an eligible Employee of a Participating Company
- The date the Charter Communications, Inc. Welfare Benefit Plan or the Short Term Disability Program is terminated or amended so that coverage is no longer available to you
- The date your eligibility for Company disability benefits ends and you have not returned to work
- The date you participate in a strike or lock-out
- The last day you are in active employment except as provided under the leave of absence provision
- The date you cease to be an eligible Employee
- The date of your death

What Happens During a Leave of Absence?

If you are granted a leave of absence from the Participating Company, your coverage in the Plan will continue for a certain period of time (with your benefit based on your Covered Compensation before your leave began).

- For Family Medical Leave, disability coverage terminates at the end of the month in which the leave exhausts.
- For Military Leave, disability coverage terminates at the end of the month in which the 13th week of Military Leave occurs. Additionally, exclusions apply for acts of war. Please see the “What's Not Covered under Short-Term Disability” section for more information.
- For Personal Leave, coverage terminates at the end of the month following the month in which the Personal Leave begins.
- For Worker's Compensation, disability coverage will continue as described above if Family Medical Leave or Personal Leave runs concurrently. Otherwise, disability coverage terminates at the end of the month in which the Worker's Compensation begins.

After your disability coverage terminates, you cannot initiate a new disability claim, but you continue to receive disability payments as long as you meet the definition of disability and other program requirements.

Important information about your premiums for health, dental, and vision coverage during your short-term disability: Benefit premiums are taken from your paycheck when you use accrued sick, personal and vacation time during your disability. After your accrued sick, personal, and vacation time has been exhausted, the Charter Benefits Center will enroll you in a direct bill process by which you will be invoiced each month for benefits coverage. Your direct bill

invoice must be paid by the due date in order to continue your health, dental and vision coverage during your short-term disability.

To continue to qualify for the “active employee rate” for benefit premiums during a leave of absence when you are not using accrued sick, personal, or vacation time, you must be approved for FMLA or personal leave. The “active employee rate” for benefits continuation coverage applies for the following periods:

Family & Medical Leave	Personal Leave (Medical & Non-Medical)
Coverage to the end of the month in which your approved leave ends	Coverage to the end of the month following the month in which your approved leave begins

Once you reach the maximum coverage period as noted in the table above, the “COBRA rate” for premiums for health continuation coverage (generally, 102% of the cost of coverage) applies, and other benefits provided by the Company, such as life insurance, end.

If your absence is due to a short-term disability or leave due to a workplace related injury, but you do not simultaneously qualify for FMLA or personal leave, you are not eligible to continue coverage at the “active employee rate” for premiums. Coverage in which you are enrolled when your short-term disability or leave due to your workplace injury begins will continue through the end of the month in which your leave commences. You will be given an opportunity to elect COBRA continuation coverage, and if so elected, you must pay the “COBRA rate” to continue coverage after the end of the month in which your short-term disability or leave due to a workplace injury begins.

Paying for Your Coverage

The Company pays the full cost of Short-Term Disability Coverage. This benefit is considered taxable income.

As a condition of entitlement to a benefit under the Plan, Employees must keep the Plan informed of their current mailing address and other relevant contact information. If the Plan is unable to locate any individual otherwise entitled to a benefit payment hereunder after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits.

HOW THE SHORT-TERM DISABILITY PROGRAM WORKS

In general, the Short-Term Disability Program replaces a percentage of your pre-disability income if you are unable to work due to a Non-Occupational Illness or Injury. Benefits under the Plan are subject to change.

Elimination Period

If Short-Term Disability benefits are approved by the Claims Administrator, benefits begin on the later of your eighth consecutive calendar day of total disability (as defined below) or upon exhaustion of accrued paid time-off provided by your Participating Company – whichever is later, unless otherwise required by state law. For purposes of the Short-Term Disability Program, the order for using paid time-off is sick, personal and vacation time.

Important information about coordination of Short-Term Disability Program benefits with state laws: Certain state laws provide exceptions or additional requirements to the general Elimination Period rules. Please check with the Claims Administrator for the process applicable to your state of employment or the state in which you live. For example, to be in compliance with state-specific mandates, if you work or live in the state of Wisconsin, and you are filing for Short-Term Disability concurrent with FMLA for your own illness, you are not required to use accrued sick, personal and vacation time.

Maximum Length of Benefit

The maximum period for which you can receive Short-Term Disability benefits, which includes the Elimination Period, will be 26 weeks minus (if applicable) any regular wages and accrued sick, personal or vacation time.

If you remain disabled past the maximum 26-week Short-Term Disability period, which includes the Elimination Period, you may be eligible for Long-Term Disability. Review the SPD for the Long-Term Disability Program or contact the Charter Benefits Center at 877-892-2367 for more information.

Frequency of Benefit Payment

You will receive your Short-Term Disability benefit at the same frequency you received your Participating Company paycheck.

Maternity Benefit

The benefit period, which includes the Elimination Period, for a normal vaginal delivery is six weeks from delivery, and the benefit period for a C-section is a maximum of eight weeks from delivery. The benefit period for a childbirth disability may also include the portion of the disability connected to complications associated with the pregnancy or as a result of delivery. In these circumstances when complications are involved, the benefit period for childbirth may

potentially be greater than the maximums presented above for a normal vaginal and C-section delivery.

Mental Health Benefit

If the benefit period for Mental Illness or a mental health related disability, such as stress, is 30 calendar days or more, a Psychiatrist must supervise treatment. The initial treatment by a Psychiatrist must occur within 30 days from your first day absent from work. Please contact the Claims Administrator immediately at **877-892-6707** if you would like assistance in locating or scheduling an appointment with a Psychiatrist.

How Your Benefit is Determined

Your benefit amount is based on your active Covered Compensation as of your last day Actively at Work. Your benefit amount increases (up to the applicable limit) or decreases automatically while you are Actively at Work.

Process to estimate Short-Term Disability payment:

1. Multiply your weekly Covered Compensation by 75% (for weeks 2-12 of disability) or by 66 2/3% (for weeks 13-26 of disability).
2. Subtract from number 1 any Deductible Sources of Income (as described below). The total benefit payable to you on a weekly basis will not exceed 100% of your monthly earnings.

After the elimination period, if you are disabled for less than 1 week, you will receive a pro-rated portion of your Short-Term Disability benefit based on your work schedule. There is no minimum amount or maximum amount unless otherwise required by state law.

Benefit Offsets (also called "Deductible Sources of Income")

Your Short-Term Disability benefit amount is reduced by the following income or benefits you receive or may be entitled to receive:

- Primary Social Security payment
- State disability benefits (HI, CA, NY, NJ, RI, PR)
- Disability benefits you receive under the Jones Act
- Pension payments (other than 401(k), profit sharing or thrift plans), other than from a Participating Company
- Third-party benefits other than those specifically covered pursuant to an employment contract
- Severance payments
- Amounts provided by your Participating Company's salary continuation program (if any)
- Income from rehabilitative employment that, combined with your coverage amount, exceeds 100% of your Covered Compensation

- The amount for which you are eligible under any work loss provision in mandatory “no fault” auto coverage
- That portion of a settlement or judgment, minus any associated costs, of a lawsuit that compensates you for your loss of earnings
- Canada and Quebec pension plans payments
- Any amount provided under federal maritime law.

Sources of Income that Are Not Deductible

The following sources of income will not reduce your Short-Term Disability benefit:

- 401(k) plans
- Profit sharing and thrift plans
- Tax-sheltered annuities
- Stock ownership plans
- Non-qualified plans of deferred compensation
- Military pension or disability income plans
- Credit disability insurance
- Franchise disability income plans
- Individual Retirement Accounts (IRAs)

For more information about whether a specific income source would offset a disability payment provided, please contact the Claims Administrator.

Rights of Recovery

The Plan Administrator or the Claims Administrator, on behalf of the Company, has the right to recover any overpayment of Short-Term Disability benefits caused by any event including but not limited to fraud, error by the Plan Administrator, the Claims Administrator, the Company, or a Participating Company in processing a claim, or your receipt of Deductible Sources of Income.

It is required that full reimbursement be made to the Plan Administrator, on behalf of the Company. The Claims Administrator or the Plan Administrator, on behalf of the Company, may recover an overpayment by, but not limited to requesting a lump sum payment of the overpaid amount, reducing any benefits payable under the Short-Term Disability Program, taking any appropriate collection activity available including any necessary legal action, and placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any Deductible Sources of Income or Sources of Income that Are Not Deductible whether on a periodic or lump sum basis.

By participating in and accepting benefits from the Short-Term Disability Program, you agree that any amounts you recover from a third party based on the injury or illness that forms the basis for your claim for benefits under the Short-Term Disability Program and that are Deductible Sources of Income described above will be subject to the Plan’s Rights of Reimbursement and Subrogation (described later in this booklet).

When Short-Term Disability Benefit Payments End

Short-Term Disability benefit payments will end on the earliest of:

- The date you fail to provide proof of continued disability and Regular Care of a Health Care Provider
- The date you fail to cooperate in the administration of a claim, including but not limited to providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse to a job with Charter where workplace modifications or accommodations were made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own job on a part-time basis, but choose not to
- The end of the maximum benefit period
- The date you die.

What Qualifies as a Short-Term Disability?

You must meet the definition of "totally" or "partially" disabled to be eligible for Short-Term Disability benefits once you have been totally disabled for the Elimination Period. Please note that you must be totally (rather than partially) disabled for the Elimination Period before you can become eligible for Short-Term Disability benefits.

Totally Disabled

You are considered totally disabled during the Elimination Period if you cannot perform the Essential Duties of your own occupation due to a Non-Occupational Illness or a Non-Occupational Injury.

You are considered totally disabled after the Elimination Period if:

- You are earning less than 20% of your pre-disability Covered Compensation due to a Non-Occupational Injury or Non-Occupational Illness (including Mental Illness, Substance Abuse and pregnancy); and
- You cannot perform the Essential Duties of your own occupation.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Partially Disabled

You are considered partially disabled if:

- You are able to work part-time for any employer performing some, but not all, of the Essential Duties of your own occupation;
- You cannot earn more than 80% of your pre-disability Covered Compensation. (See the Partial Short-Term Disability Benefit section for more information); and
- For an Exempt Employee, a Health Care Provider releases you to return to work for less than 4 hours of your scheduled workday.

A claim of Total Disability or Partial Disability cannot be based solely on Self-Reported Symptoms. Total Disability and Partial Disability must be based at least in part on objective evidence, which means the following:

- Diagnosis determination by the physician by use of tests, imaging, clinical studies, medical procedures and other physical evidence;
- Intensity and frequency of treatment, including your physical response and any symptoms associated with treatment; and
- Presence of other health conditions, injuries and illness.

You must be under the Regular Care of a Health Care Provider throughout your disability for Short-Term Disability benefits to be payable. The Claims Administrator may have you examined at its expense from time to time, and may request that you provide other satisfactory proof of your continued disability.

There are no pre-existing condition exclusions under the Short-Term Disability Program.

What's Not Covered under Short-Term Disability?

The Short-Term Disability Program does not pay benefits for a disability that results from:

- Intentionally self-inflicted injuries, including a disability or injury that results from the use of hallucinogenic or narcotic drugs, except when legally prescribed by a Health Care Provider and taken in accordance with the Health Care Provider's instructions
- Active participation in a riot
- Commission of a felony for which you have been convicted
- Loss of a professional license, occupational license or certification
- War, declared or undeclared, or any act of war, in either case where the Employee is eligible to receive military benefits due to the injury or illness, unless the disability was incurred while on Company business
- Cosmetic surgery, except for complications arising from the surgery or surgery made necessary by accidental injury or illness while covered by the Disability Program
- Injury or illness sustained during any period of incarceration
- An occupational or work related illness or injury

Other Information You Should Know About Short-Term Disability Coverage

State-mandated (Statutory) Benefits If you work in California, or Rhode Island, and you believe you are entitled to short-term disability benefits, you should apply directly to the state in

which you work. If you work in New York or New Jersey, you may be eligible for short-term disability benefits under separate group insurance contracts maintained by the Participating Company to satisfy short-term disability requirements in those states. These payments, if any, are not part of this Disability Program, and the estimated income from any state-mandated disability benefit would offset benefits paid under this Disability Program, if continued beyond the Elimination Period. Please contact the Claims Administrator for more information about filing a claim with the applicable state.

Partial Short-Term Disability Benefit You may be eligible for a partial Short-Term Disability benefit if you can perform at least one of the Essential Duties of your job or another job; you have at least 20% or more loss in weekly Covered Compensation due to the same sickness or injury; and you have satisfied the Elimination Period. Once the Claims Administrator has approved the payment of Short-Term Disability benefits for a partial disability, you get a percentage of your Short-Term Disability benefit equal to the ratio of your loss of earnings to your pre-disability Covered Compensation. An Exempt Employee who returns to work for 4 hours or more of the scheduled workday is not eligible for partial disability.

Recurring Disability If the disability for which you received Short-Term Disability Program benefits recurs within 30 consecutive calendar days after you return to work as an Employee, it will be treated as the same or related disability, and Short-Term Disability benefits will resume immediately; you do not need to complete a new Elimination Period. If the disability recurs after 30 days, or if you suffer from a second injury, illness, health condition or diagnosis within 30 days, it will be treated as a new disability, and Short-Term Disability benefits will start after you have completed another Elimination Period applicable to the new disability.

CLAIM PROCESSING AND YOUR RIGHT TO APPEAL

Filing a Short-Term Disability Claim

The Short-Term Disability Program is a component program of the Charter Communications, Inc. Welfare Benefit Plan, which is an Employee Retirement Income Security Act of 1974 (ERISA) plan and subject to the claims procedures applicable to disability benefits. All claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Eligibility Determination

Determinations of eligibility to participate in the Short-Term Disability Program will be made by the Plan Administrator rather than the Claims Administrator, but will generally follow the same process as claims decisions outlined in this section. If you have questions about your eligibility, you should contact the Benefits Service Center at 877-892-2367. If you would like to request a formal determination of your eligibility to participate in the Short-Term Disability Program or believe that a determination of your eligibility to participate in the Short-Term Disability was incorrect, please contact:

Claims & Appeals Management – Charter Communications, Inc.
P.O. Box 1407
Lincolnshire, IL 60009-1407
or fax to: 1-847-554-1808

877-892-2367 (to request a claim form)

Reporting a Short-Term Disability Claim

The Claims Administrator is the claims fiduciary with sole authority to determine benefit claims under the terms of the Short-Term Disability Program. If you have a claim under the Short-Term Disability Program, you're encouraged to notify the Claims Administrator as soon as possible but no later than 30 days after the date of your disability. You may designate a representative to act on your behalf in pursuing a claim or appeal, but this designation must be explicitly stated in writing and must authorize disclosure of protected health information with respect to the claim. If you would like to designate a representative, you will need to contact the Claims Administrator. If you wish to waive your disability benefit, please contact the Claims Administrator.

You will be required to give the Claims Administrator your authorization to obtain additional medical information from your Health Care Provider. You may also be required to provide other medical or non-medical information in support of your claim for disability benefits. For example, you may be asked by the Plan Administrator or the Claims Administrator to furnish proof of your continued disability or objective evidence of the diagnosis, treatment, and/or presence of other health conditions, injuries or illness. If you do not give your authorization or

provide other medical or non-medical information as requested (by the 20th calendar day after the date such information is requested), the Claims Administrator may deny your claim or stop sending you payments.

Claims Timeline

Within 45 days after you have filed a written claim with the Claims Administrator, the Claims Administrator will notify you of its decision. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the necessary information accompanies the filing. If the Claims Administrator needs more time to examine your request because of matters beyond the control of the Claims Administrator, you will be informed within these 45 days that additional time is needed, why it is needed and the date by which you can expect to receive a decision.

Consideration of your request may be extended twice (by 30 days each time) if it is determined that each extension is necessary due to matters beyond the Claims Administrator's control and you are notified of these circumstances in advance. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension will begin after you have provided that information. If your claim is wholly or partially denied, the Claims Administrator will provide a written explanation in accordance with ERISA.

If your claim is approved, disability payments will be made to you. If benefits are denied for any reason, you have the right to appeal the denial. See *Your Rights to Appeal a Short-Term Disability Denial* below.

Once benefits start, the Claims Administrator reserves the right to request periodic reexaminations to verify your continuing disability. For Short-Term Disability claims, if the Claims Administrator requests the periodic reexamination, the costs associated with that reexamination are at your expense.

Your ERISA Rights to Appeal a Short-Term Disability Denial

If your Short-Term Disability claim is denied, you have the right to appeal your denial. A claim denial notice will include:

- The specific reason or reasons for the denial;
- The specific Plan provisions on which the determination is based;
- A description of the Plan's internal claim and appeals procedures (including the time limits applicable to such procedures) and a statement regarding the claimant's right to bring a civil action under ERISA following a final adverse determination on review;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

- If the claim is denied based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Short-Term Disability Program to your medical circumstances, or a statement that such explanation will be provided upon request; and
- A description of any internal rule, protocol or similar criterion that the Claims Administrator relied on to deny the claim and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

Your disability plan allows for one appeal of your denied claim. It will be important for you to submit all relevant documentation when you request your appeal.

Appeal Procedure

You may appeal a denied claim within 180 days following an adverse benefit determination. In most cases, the Claims Administrator will review and decide on the appeal within 45 days of receipt of your written request. The period of time within which a benefit determination on review is required to be made shall begin upon receipt of the written request, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, the Claims Administrator may notify you there is a special circumstance which requires a delay and provide the date by which the administrator expects to render the determination on review. There may be a limited extension (not to exceed 45 days) of the review and decision-making process. If an extension is necessary to decide the appeal, the notice of extension will specifically describe the required information. If you deliver the requested information within the time period specified, the 45-day extension of the appeal period will begin after you have provided the information.

You will be provided a full and fair review. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will have the opportunity to submit relevant written comments, documents, records or other information in support of your appeal. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. The review will be conducted by the Claims Administrator and will be made by a person different from the person who made the initial determination, and such person will not be the original decision-maker's subordinate.

In the case of a claim denied on the grounds of a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Claims Administrator in connection with the denial of your claim, the Claims Administrator will provide you with the names of each such expert, regardless of whether the advice was relied upon.

Appeal Timeline

Within 45 days after you have filed a written claim with the Claims Administrator, the Claims Administrator will notify you of its decision. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the necessary information accompanies the filing. If the Claims Administrator needs more time to examine your request because of matters beyond the control of the Claims Administrator, you will be informed within these 45 days that additional time is needed, why it is needed and the date by which you can expect to receive a decision.

Consideration of your request may be extended twice (by 30 days each time) if it is determined that each extension is necessary due to matters beyond the Claims Administrator's control and you are notified of these circumstances in advance. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension will begin after you have provided that information. If your claim is wholly or partially denied, the Claims Administrator will provide a written explanation in accordance with ERISA. An appeal denial notice will include:

- The specific reason or reasons for the denial;
- The specific Plan provisions on which the determination is based;
- A description of any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures (including the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what might be available is to contact your local U.S. Department of Labor Office and your state's insurance regulatory agency.");
- A statement regarding the claimant's right to bring a civil action under ERISA section 502(a);
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
- If the appeal is denied based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Short-Term Disability Program to your medical circumstances, or a statement that such explanation will be provided upon request; and
- A description of any internal rule, protocol or similar criterion that the Claims Administrator relied on to deny the appeal and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

Exhaustion of Claims and Appeals Process

Upon completion of the claims and appeals process, you will have exhausted your administrative remedies under the Disability Program. No action at law or in equity may be brought with

respect to Disability Program benefits until all rights under the Disability Program have been exhausted and any such action must be brought no later than one year from the date the Plan Administrator's or Claims Administrator's final decision upon review of an appeal or the expiration of the applicable limitations period under applicable law (whichever is earlier).

Time Limit on Legal Actions Following the Denial of an Appeal

Any legal action brought by a claimant following exhaustion of the Plan's claims and appeals process must be brought within one year following the claimant's receipt of the denial of the claimant's claim for benefits on appeal, or such claim shall be forfeited and forever barred by the Plan's limitation on the time period during which such legal actions may be commenced.

Claim or Eligibility Fraud

The Claims Administrators may evaluate claims to detect fraud or false statements and will notify the Company regarding these matters. If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representation, the Claims Administrator or the Plan Administrator, in its discretion, may seek reimbursement and may elect to pursue the matter by pressing criminal charges to the maximum extent allowable by law. In addition, an employee who provides fraudulent information with respect to any claim for benefits may be subject to disciplinary action up to and including termination of employment at the discretion of Charter or the other Participating Company.

Uncashed Checks

As a condition to any benefit entitlement under the Plan, any person claiming the benefit must present for payment the check evidencing such benefit within one year of the date of issue. If any check for a benefit payable under the Plan is not presented for payment within one year of the date of issue, the Plan shall have no liability for the benefit payment, the amount of the check shall be deemed a forfeiture, and no funds shall escheat to any state.

PLAN ADMINISTRATION AND OTHER IMPORTANT INFORMATION

Compliance with Federal Law

The Plan and the Short-Term Disability Program are subject to ERISA and its applicable regulations. The Plan will be construed to comply with these regulations, rulings and laws (including the Internal Revenue Code and its regulations). Further, the Plan and the Short-Term Disability Program will comply, to the extent applicable, with the requirements of all applicable laws (including amendments thereto).

Amendment or Termination of Plan

The Company or any successor reserves the right to amend, modify, suspend or terminate the Charter Communications, Inc. Welfare Benefit Plan, including the Short-Term Disability Program, in whole or in part, at any time and for any reason, by action of the Company or its delegate. In addition, the Company has delegated the authority to amend the Plan and the Short-Term Disability Program to the Benefits Officer in certain circumstances.

Plan Facts

Plan Name	Charter Communications, Inc. Short-Term Disability Program, a component program under the Charter Communications, Inc. Welfare Benefit Plan
Type of Plan	Welfare benefit plan; short-term disability benefit
Plan Sponsor	Charter Communications, Inc. 12405 Powerscourt Drive St. Louis, MO 63131-3674
Employer Identification Number	84-1496755
Plan Number	507
Plan Administrator and Named Fiduciary	Charter Communications, Inc. 12405 Powerscourt Drive St. Louis, MO 63131-3674 314-965-0555
Claims Administrator and Claims Fiduciary	Sedgwick 1100 Ridgeway Loop Road Memphis, TN 38120 Phone: 1-877-892-6707 Fax: 859-280-2880
Third-Party Administrator for Eligibility	Aon Hewitt P.O. Box 1407 Lincolnshire, IL 60069-1407

Insurer for Mandated Benefits in New Jersey and New York	<p>The New Jersey Temporary Disability coverage is insured by Liberty Life Assurance Company of Boston under Policy number GS3-840-444809-NJ.</p> <p>175 Berkeley Street Boston, MA 02117 Phone: 844-384-5858</p> <p>The New York State Disability coverage is insured by Liberty Life Assurance Company of Boston under Policy number GS3-840-444809-NY.</p> <p>175 Berkeley Street Boston, MA 02117 Phone: 844-384-5858</p>
Agent for Service of Legal Process	<p>For disputes arising under the Short-Term Disability Program, service of process may be made upon the Plan Administrator or the applicable Claims Administrator at the addresses above, or upon the Plan Sponsor's registered agent at the following address:</p> <p>Corporation Service Company 2711 Centerville Road, Suite 400 Wilmington, DE 19808</p>
Plan Year	<p>January 1 – December 31</p>
Plan Funding	<p>The Short-Term Disability Program (except for locations in NY and NJ) is self-funded and paid from the Company's general assets. Short-Term Disability coverage for locations in NY and NJ are insured. The Company pays the cost of coverage. No contributions are required from Employees.</p>
Participating Companies in the Charter Communications, Inc. Welfare Benefit Plan	<p>Charter Communications, Inc. Charter Communications, LLC</p>

Plan's Rights of Subrogation and Reimbursement

For purposes of the Plan's Right of Subrogation and the Plan's Right of Reimbursement, the following definitions shall apply:

"Covered Individual" means an individual who is eligible for and enrolled in the Plan and the applicable program, and includes such individual's guardian, executors, heirs, estate or other legal representative.

"Responsible Party" means any person or entity which commits an act or omission that caused a Covered Individual's illness or injury that gave rise to an expense or charge that the Covered Individual seeks to have paid or reimbursed by the Plan.

"Third Party" means any person or entity (including, but not limited to, an insurance company), which is not the Covered Individual, from which a Covered Individual may seek compensation for illness or injury because it is believed that an act or omission of a Responsible Party caused the illness or injury that gave rise to an expense or charge that the Covered Individual seeks to have paid or reimbursed by the Plan. A Third Party may be the Responsible Party or any person or entity who may be required to make payment on behalf of the Responsible Party.

As a condition of a Covered Individual participating in and receiving benefits under the Plan, the Covered Individual agrees that, in the event the Covered Individual has a claim for damages against a Third Party arising out of or relating to an illness or injury as a result of the act or omission of a Responsible Party, the Plan shall (to the extent of any benefits paid, payable, or expected to be paid by the Plan relating to such illness or injury resulting from the act or omission of the Responsible Party and including any expenses incurred by the Plan to enforce its rights) be subrogated to all of the Covered Individual's rights of recovery from the Third Party (the "Right of Subrogation"). If the Plan is precluded from exercising, or chooses not to exercise its Right of Subrogation, it nonetheless may choose in its discretion to pay benefits.

The Covered Individual also agrees that, in the event the Covered Individual suffers an illness or injury as a result of the act or omission of a Responsible Party and the Covered Individual collects payment from a Third Party, then the Covered Individual must reimburse the Plan in full from any payment received from a Third Party to the extent of any benefits paid, payable, or expected to be paid by the Plan relating to such illness or injury resulting from the act or omission of the Responsible Party and including any expenses incurred by the Plan to enforce its rights (or, if less, the full amount collected from the Third Party) (the "Right of Reimbursement").

The Plan Administrator may choose, in its discretion, to exercise only the Right of Subrogation or the Right of Reimbursement, or both. The Plan's waiver of its Right of Subrogation or Right of Reimbursement with respect to one claim shall not constitute a waiver of its Right of Subrogation or Right of Reimbursement with respect to another claim; and the Plan's waiver of its Right of Subrogation or Right of Reimbursement with respect to one Interested Party shall not

constitute a waiver of its Right of Subrogation or Right of Reimbursement with respect to another Interested Party.

By participating in and accepting benefits from the Plan, a Covered Individual agrees that the Plan has the right to “first dollar” recovery; that is, the Plan’s claim for subrogation and/or reimbursement has priority over any other claim to the funds paid by the Third Party and takes precedence over the claims of any other entity, including any claims for pain and suffering, other non-medical charges, claims for attorneys’ fees, and other costs and expenses. The subrogation and reimbursement rights of the Plan are primary, regardless of whether the Covered Individual has made a full or partial recovery from a Third Party. The “make whole” rule is inapplicable to the Plan, so that the Plan’s rights override any interest a Covered Individual may have to be made whole before reimbursing the Plan for amounts that it paid.

The Plan’s rights of subrogation and reimbursement apply regardless of whether fault or liability for payment is admitted by the Responsible Party or a Third Party, regardless of whether any settlement or judgment received by the Covered Individual identifies the benefits provided under the provisions of the Plan, and regardless of how the recovery is designated (e.g., as payment for expenses or otherwise). The Plan’s rights of subrogation and reimbursement apply to all amounts recovered or recoverable from the Responsible Party or a Third Party (whether by litigation, arbitration, settlement of a claim, or otherwise), including a right to any property to which the original recovery is converted.

In its sole discretion, the Plan Administrator may condition benefits upon a Covered Individual’s execution of a written agreement to subrogate the Plan, reimburse the Plan, and/or assign payments from a Third Party to be made directly to the Plan, and may condition any future or continuing benefit payments on compliance with these provisions. The Plan does not waive its right to subrogation, reimbursement, or assignment should it waive the right to receive a subrogation, reimbursement or assignment agreement from the Covered Individual prior to the advancement of any monies to or on behalf of the Covered Individual.

If the Covered Individual receives benefits or expects that benefits will be paid under the Plan for an illness or injury that is a result of the act or omission of a Responsible Party, the Covered Individual agrees to (i) immediately notify the Plan Administrator of any and all Responsible Parties and Third Parties which the Covered Individual may have a claim against as a result of the illness or injury, including but not limited to, any insurance company providing coverage to the Covered Individual; (ii) immediately notify (by registered mail) the Plan Administrator of any and all claims for damages made by or on behalf of the Covered Individual in connection with the illness or injury; (iii) automatically assign to the Plan any right to recover payments and any actual recovery from any Responsible Party or Third Party; (iv) recognize the Plan’s right to recover its payment for Plan expenses from the Responsible Party or a Third Party who caused (or is liable for) the illness or injury related to the Plan’s benefit payments; (v) repay to the Plan the benefits and/or expenses paid on the Covered Individual’s behalf out of any recovery made from the Responsible Party or Third Party; (vi) fully cooperate with the Plan Administrator to provide information about the illness or injury and to take such action to furnish relevant

information and assistance and to execute and deliver all necessary instruments as may be required by the Plan; (vii) fully cooperate with the Plan Administrator in collecting from the Responsible Party or a Third Party (if a claim is settled without protecting the Plan's interest, a Covered Individual's rights to full compensation may be lost); (viii) accept no distribution of any settlement or other proceeds unless and until the Plan's interest has been paid to the satisfaction of the Company (or its delegate); and (ix) refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery under its right of subrogation or reimbursement, as applicable.

By participating in and accepting benefits from the Plan, a Covered Individual agrees that (i) any amounts recovered by the Covered Individual from a Third Party shall constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Individual), (ii) the Covered Individual shall be a fiduciary of the Plan (within the meaning of ERISA §3(21)) with respect to such amounts, and (iii) the Covered Individual shall be liable for and agrees to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its rights. If a Covered Individual recovers from a Third Party before payment to the Plan, then any money that a Covered Individual recovers must be and is deemed to be held in trust for the benefit of the Plan to the extent of the amount of Plan benefits provided, with the Covered Individual as trustee and fiduciary. In the case of a Covered Individual who is a minor, any settlement or award received by the minor or his or her trustee, guardian, parent or other representative will be subject to this provision regardless of state or federal law and/or whether his or her representative has access to or control over any recovered funds.

The Plan has the following rights: (i) to place a first priority lien against any Responsible Party or Third Party to the extent of the benefits paid; (ii) to bring an action on its own behalf, or on behalf of the Covered Individual, against any Responsible Party or Third Party; (iii) to join any action filed by or on behalf of a Covered Individual in order to recover benefit payments made (or expected to be made) by the Plan; (iv) to suspend the payment of any benefits under the Plan pending receipt from the Covered Individual of the acknowledgement, authorization, waiver or release it deems necessary to exercise its rights and privileges; (v) to reduce the amount payable to or on behalf of such Covered Individual for current or future expenses until the Plan has made a full recovery; and (vi) make a demand on or bring legal action against the Covered Individual directly. The Plan will be entitled to apply for and receive an injunction to restrain any violation of these provisions of its right to collect the money (or to take such other action necessary to enforce its rights). The Plan has the right to recover from a Covered Individual an amount equal to the amount paid by the Plan with interest at 5% per annum, or whatever smaller amount is recovered by the Covered Individual.

The Plan has a right to payment or reimbursement for any legal fees it expends in exercising its right to subrogation. Also, the recovery rights of the Plan outlined in this provision will not be reduced to reflect the Covered Individual's costs or attorney's fees incurred in obtaining a recovery, unless separately agreed to, in writing, by the Company (or its delegate) in the exercise of its sole discretion. The Plan's rights of subrogation and reimbursement will not be defeated or

reduced by the so-called “fund doctrine,” “common fund doctrine,” or “attorney’s fund doctrine.”

The Plan’s rights shall remain in effect until the Plan is repaid in full or until the claim is settled by the Company (or its delegate).

YOUR RIGHTS UNDER ERISA

Benefits provided by the Plan are covered by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The law does not require the Company to provide these benefits, but it does set certain standards for any that are offered.

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, all documents governing the Plan (including collective bargaining agreements and insurance policies and/or contracts, if any, where applicable) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration; the Corporate Benefits Department has these documents available, and you may make an appointment to examine them at any time during business hours
- Obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD by requesting these materials in writing; you may obtain copies by writing to the Plan Administrator; the Company reserves the right to make a reasonable charge for copying any documents you request
- Receive a summary of the annual financial report of the Plan; you do not need to request the summary annual report; the Company provides this information to all Plan Participants once a year

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes obligations on the persons responsible for the operation of an employee benefit plan. These people, referred to as fiduciaries of the Plan, have an obligation to administer the Plan prudently and to act in the interest of the Plan Participants and their beneficiaries. The law provides that fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan. No one, including your Participating Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a Plan Participant. For instance,

- If your claim for benefits to the Claims Administrator or Plan Administrator (as applicable) is denied in full or in part, you have a right to know why this was done, to

obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. At the completion of that review process, you have a right to file suit in federal or state court.

- If Plan fiduciaries misuse the Plan's funds or if you are discriminated against for asserting your rights, you have a right to seek assistance from the U.S. Department of Labor, or you may file suit in federal court.
- If you submit a written request for copies of any Plan documents or the latest annual report from the Plan and you do not receive those materials within 30 days of your request, you may file suit in a federal court. If a violation exists, the court may require the Plan Administrator to provide the material and to pay you up to \$110 for each day's delay. This provision does not apply, however, if the requested materials were not sent to you because of reasons beyond the control of the Plan Administrator.

In these circumstances, the court will decide who should pay court costs and legal fees. In other words, if you are successful, the court may order the party you have sued to pay these costs and fees. But if you lose, the court may order you to pay the costs and fees (for example, if the court finds that your claim is frivolous).

If you believe that the Plan Administrator or Claims Administrator (as applicable) has improperly denied you benefits under this Plan, please remember that you must complete each step of the applicable claims procedure, within the deadlines, before you can take any legal action.

If it should ever become necessary for you or your beneficiary to take legal action to enforce your rights under ERISA or the terms of the Plan, legal process may be served on the Plan Administrator or Claims Administrator (as applicable).

A Final Word About Your Rights

Your rights can be determined only by referring to the full text of the Plan documents, which are available for your inspection from the Plan Administrator. The Company encourages you to contact the Benefits Service Center if you should have any questions about the foregoing statements or about your rights under ERISA.

Assistance with Your Questions

You may also contact the nearest office of the Employee Benefits Security Administration, US Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor (200 Constitution Avenue N.W., Washington, D.C. 20210) to discuss questions about this statement of rights or about any rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator. You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Actively at Work means performing your regular job functions for your regularly scheduled work hours at your usual place of business or other location to which you are required to travel on business and includes vacation, personal days and holidays except if used concurrently with a leave of absence. You must be Actively at Work for any coverage or any increase in Short-Term Disability Program amounts to become effective.

Charter Communications, Inc. Welfare Benefit Plan refers to the Charter Communications, Inc. Welfare Benefit Plan, a consolidated welfare benefits plan providing medical, prescription drug, dental, vision, life, accidental death and dismemberment (AD&D), short-term disability, long-term disability and employee assistance program benefits to eligible Employees and their dependents.

Claims Administrator is the applicable company that reviews certain types of claims directly and is responsible for determining whether benefits may be payable under the Plan. The Claims Administrator determines the amount of, and administers the payment of, any such benefits under the Plan.

Covered Compensation depends on whether you are a commissioned or non-commissioned Employee. The definition applies to weekly Covered Compensation for.

- **Non-commissioned Employees:** Covered Compensation is your gross regular salary or income from your Participating Company in effect just prior to your date of disability. It is your Annual Benefits Base Rate (ABBR) and represents total regular salary or wages before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any fringe benefit or extra compensation or income received from sources other than your Participating Company.
- **Commissioned Employees:** Covered Compensation is your average regular pay from your Participating Company in effect just prior to your date of disability. It is your Annual Benefits Base Rate (ABBR) and represents total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It includes commissions and sales incentives, but does not include income received from bonuses, overtime pay, any fringe benefit or extra compensation or income received from sources other than your Participating Company.

Deductible Sources of Income means income from sources that you receive while you are disabled. This income will be subtracted from your Gross Disability Payment.

Elimination Period is the time period after you first become disabled before benefits under the Short-Term Disability Program become payable.

Employee means a regular full-time individual who is employed by a Participating Company and regularly scheduled to work at least 30 hours per week. Individuals employed in the state of Hawaii are not considered eligible Employees for purposes of participation in the Short-Term Disability Program. An individual classified by the Company as an independent contractor or temporary employee, or any individual who renders services for a Participating Company while on the payroll of an entity other than a Participating Company, shall not be deemed to be an Employee, even if any agency or organization reclassifies the independent contractor as a common law employee or even if such individual is deemed to be a common law employee of a Participating Company for any other purpose. Further, a leased employee (as defined in Internal Revenue Code Section 414(n)) shall not be deemed an Employee.

An individual shall not be an Employee and shall not be eligible to become a Participant if the individual is included in a unit of employees covered under a collective bargaining agreement entered into between the Company and employee representatives, if benefits were the subject of good faith bargaining between the Company and the employee representatives and the collective bargaining agreement does not provide that such individuals shall participate in the Plan or a portion of the Plan.

Essential Duty means the important tasks, functions and operations generally required by employers from those engaged in their usual occupation that cannot be reasonably omitted or modified.

Exempt Employee means an Employee who is defined by the Federal Labor Standards Act (FLSA) as being exempt from this law's minimum wage and overtime requirements.

Gross Disability Payment means the benefit amount before the Claims Administrator subtracts Deductible Sources of Income.

Health Care Provider means a Physician, surgeon or Psychologist who is licensed and acts within the scope of his/her practice or a nurse practitioner or a nurse midwife who is licensed to practice under State law and performs tasks within the scope of his/her license as defined under State law. A Health Care Provider cannot be you or your spouse, domestic partner, child, parent or sibling based on a biological, marital, adoptive, foster care or "in loco parentis" relationship.

Hospital means an accredited facility licensed to provide care and treatment for the condition causing a disability.

Mental Illness means a psychiatric or psychological condition, regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment.

Non-Occupational Illness is an illness or disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does. A disease is considered

non-occupational regardless of its cause if proof is furnished that the person is covered under any type of Workers' Compensation law, and not covered for that disease under such law.

Non-Occupational Injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury that does.

Participant means an Employee who satisfies the Short-Term Disability Program's eligibility requirements.

Participating Company means Charter Communications, Inc. or any successor and its affiliated companies that participate in the Plan and the Short-Term Disability Program. The Participating Companies are shown in the Participating Companies list in the Plan Facts subsection.

Physician means a person who is licensed to practice medicine and prescribe and administer drugs and who performs tasks within the scope of his/her license.

Plan Administrator for the Plan is the Administrative Committee appointed by the Company, or if no Administrative Committee is appointed, the Company.

Plan Sponsor is Charter Communications, Inc. or any successor company.

Psychiatrist means a Physician who has completed an accredited residency program in Psychiatry.

Psychologist means a person with a doctoral degree in psychology (Ph.D. or Psy.D.) who is licensed to practice under State law.

Regular Care of a Health Care Provider means you personally visit a Health Care Provider as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s), and you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a Health Care Provider whose specialty or experience is the most appropriate for your disabling condition(s) according to generally accepted medical standards.

Self-Reported Symptoms mean the manifestation of your condition (what you tell your Health Care Provider) that is not verifiable using tests, procedures or clinical examinations usually acceptable in the practice of medicine. Headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy are examples of Self-Reported Symptoms.

Short-Term Disability Program means the short-term disability benefits provided under the Plan as described in this booklet.

Substance Abuse is a condition of psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications that results in functional (physical, cognitive, mental, affective, social or behavioral) impairment.